COVENTRY HEALTH CARE OF DELAWARE, INC.
QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)
$1,200 DEDUCTIBLE OPEN ACCESS HSA
(Maryland Small Group of 2 to 50 Eligible Employees)

The benefits outlined in this Schedule are in addition to the benefits offered under Coventry Health Care of Delaware, Inc. Small Employer Health Plan and Standard Package Cost Sharing for Maryland Small Employers. The benefits described herein are chosen at the Small Employer's option for an additional Premium to provide lower cost sharing for Members.

Deductible* $1,200/Individual
(Except for covered Well Child Visits and Adult Preventive Care Services described below, there is a combined annual deductible for all Covered services, including prescription drugs.) $2,400/Family

Out-of-Pocket Limit** $2,400/Individual
(Includes deductible, coinsurance and copayments.) $4,800/Family

COVERED SERVICES	**COPAYMENT/COINSURANCE**
Primary Care Services	$20 copayment
Specialty Care Services	$30 copayment
Adult Preventive Care Services (Not subject to the deductible. Eligible expenses include routine physical examinations, routine gynecological examinations, pap smears, routine mammograms, and prostate screening.)	$0 copayment
Well Child Visits (Not subject to the deductible. Includes all visits for children 0-24 months of age and visits that include immunizations for children older than 24 months-13 years of age.)	$0 copayment
Inpatient Hospitalization	$250 copayment per admission
Physician Inpatient Hospital Visits…	$20 copayment
Outpatient Laboratory Services	$30 copayment or 50% of the cost of the service, whichever is less
Outpatient Diagnostic Services	$30 copayment or 50% of the cost of the service, whichever is less
Outpatient Surgery	$30 copayment

COVERED SERVICES **COPAYMENT/COINSURANCE**

Outpatient Rehabilitative Services..... $30 copayment
(up to 30 visits for each service per condition per Contract Year)

Habilitative Services ..... $30 copayment
(for children up to age 19 with a congenital or genetic birth defect)

Chiropractic Services..... $30 copayment
(up to 20 visits per condition per Contract Year)

Durable Medical Equipment ..... $0 copayment

Hospice .... $0 copayment

Home Health Care ..... $0 copayment

Outpatient Mental Health and Substance Abuse Services ..... 30% coinsurance
(Medication Management visits are not counted towards Outpatient Mental Health Visits.)

Inpatient Mental Health and Substance Abuse Services
(2 days of partial hospitalization maybe substituted for 1 day of inpatient hospital care.)
• Inpatient Hospital Care and Residential Crisis Services. ..... $250 copayment per admission (up to 60 days per Contract Year)
• Physician Inpatient Services ..... $20 copayment

Infertility Services
• After diagnosis of Infertility has been confirmed .....50% coinsurance

Skilled Nursing Facility Services
(up to 100 days per Contract Year)..... $30 copayment per day

Prescription Drugs
All prescriptions are subject to the same deductible as all other medical services:

- Tier 1 Drugs..... Deductible applies then, $0 copayment per Prescription or refill ($0 copayment per prescription or refill for a 90 consecutive day supply for Maintenance Drugs.)
- Tier 2 Drugs..... Deductible applies then, $25 copayment per Prescription or refill ($50 copayment per prescription or refill for 90 consecutive day supply for Maintenance Drugs.)
- Tier 3 Drugs..... Deductible applies then, $50 copayment per Prescription or refill ($100 copayment per prescription or refill for 90 consecutive day supply for Maintenance Drugs.)

- Self Administered injectable (other than insulin) ..... Copay is 50% of the allowable charge not to exceed $75, after the Deductible

Allowable charge means charges for Prescription Drugs dispensed at a Participating Pharmacy that are equal to:

- the contracted rate or the rate the Health Plan has agreed to pay.

If member chooses a brand name drug when a generic is available, the member will pay the difference in price; between the price of the brand name and the generic in addition to the copay. The member is responsible for the lesser of the copayment or the cost of the prescription.

Emergency Services

- Urgent Care Center..... $30 copayment
- Hospital Emergency Room (waived if admitted) ..... $100 copayment
- Emergency Ambulance..... $0 copayment

* **Deductible:** The individual Deductible is a limit on the amount You must pay before you receive benefits. The family Deductible is the limit on the total amount Members of the same family covered under this Agreement must pay before receiving benefits.

** **Out-of-Pocket Limit:** Article 1.6 of the Membership Agreement is amended to read as follows:

The individual Out-of-Pocket Limit is the dollar amount a Member will have to pay out of his or her pocket in a contract year. When a Member has reached the individual Out-of-Pocket Limit, benefits for Covered Services are covered at the rate of 100% for the rest of that contract year.

The family Out-of-Pocket Limit is the dollar amount members of the same family will have to pay out of pocket in a contract year. The out-of-pocket limit for all covered services, including prescription drugs, child wellness, and immunization services, shall be subject to the annual out-of-pocket maximum. When a family has reached the family Out-of-Pocket Limit, benefits for Covered Services are covered at the rate of 100% for the rest of that contract year for all family members.

The Out-of-Pocket Limit includes the deductible, coinsurance and copayments.

PLEASE NOTE THAT IF YOU RECEIVE SERVICES FROM AN OUT-OF-NETWORK PROVIDER, YOUR COINSURANCE AMOUNT WILL BE APPLIED TO THE OUT-OF-NETWORK RATE TO DETERMINE HOW MUCH WE PAY FOR COVERED SERVICES PROVIDED BY THE OUT-OF-NETWORK PROVIDER. *Based on your benefit plan, You may have limited coverage for out-of-network services. Please review your group membership agreement carefully regarding when out-of-network services may be included in your coverage.*

Out-of-Network Rate: The Out-of-Network Rate is the rate we pay for claims for services rendered by a non-Participating Provider. We will pay the claims as follows:

- claims submitted by a hospital will be paid at the rate approved by the Health Services Cost Review Commission;
- claims submitted by a trauma physician for trauma care rendered to a trauma patient in a trauma center will be paid at the greater of:
- 140% of the rate paid by the Medicare program, as published by the Centers for Medicare and Medicaid Services, for the same covered service to a similarly licensed provider, or
- the rate as of January 1, 2001 that We paid in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a

similarly licensed provider; and

- claims submitted by any other health care provider will be paid at the greater of:
- 125% of the rate We pay in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider who is a Participating Provider, or
- the rate We paid as of January 1, 2000, in the same geographic area, as published by the Centers for Medicare and Medicaid Services, for the same covered service, to a similarly licensed provider who is not a Participating Provider.

This is not a contract or a definitive statement of benefits. It is intended solely to provide you with an overview of the proposed Coventry benefits. Complete details of benefits, terms and exclusions are governed by your Coventry Group Membership Agreement (GMA). **The Coventry GMA may not cover all your health care expenses. Read your GMA carefully to determine which health care services are covered. If you have questions call us toll free at 1-800-833-7423.**